NAMI CALIFORNIA

The State's Voice on Mental Illness

MEMO TO: **MHSOAC**
DATE: **April 11, 2008**
FROM: **NAMI CALIFORNIA**
PURPOSE: **Feedback on MHSA Implementation Issues**

In response to your request for feedback on MHSA implementation issues, I sent an email to our NAMI MHSA Statewide Advisory Pool. This pool is comprised of over 200 NAMI family members and NAMI consumers. I've tried to consolidate and summarize their comments by topic. These statements represent the opinions and perceptions of grassroots stakeholders and are intended to fine tune our understanding of MHSA implementation as it is being experienced by "people in the trenches." These statements do not constitute a formal position statement by NAMI California.

Thanks for all your hard work on the Commission and for your attention to complicated and challenging issues. As one person wrote, "Otherwise, I know from what I see and hear that staff, family and clients/consumers do feel a huge difference in how well they are being served. We have a ways to go but I think we are definitely making improvements in our continuum of care."

I'm sorry I can't be present at the Bakersfield MHSOAC meeting to answer questions you may have regarding these statements. Please feel free to contact me if you need further clarification.

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MHSA Transparency:

- Transparency by county mental health entities and the shaping MHSA programs to the issues identified by the community are inconsistent.

MHSA Housing

- The housing process is proceeding without sufficient client and family member participation. Decisions are being made in closed committees between housing consultants and county mental health.
- Housing programs need to include "support personnel" to help clients learn independent living skills. This support cannot be left to family members and parents who are often aging.

MHSA Family Member Involvement

- More family member involvement in the MHSA stakeholder process is needed for those clients who can't or who are unwilling to represent themselves and for clients who are not yet in the system.
- Please hold more MHSA Stakeholder meetings for those who are in the daytime workforce.

- It is important for people hired as family and client liaisons, coordinators, outreach personnel, etc. to be doing that work rather than being sucked into other positions in the case of staff cutbacks.

MHSA Operating Issues

- Responses from DMH for plan submissions are taking 6 months instead of 60 days.
- The policy change regarding 05-06 funds which previously could be encumbered by June 08 and now must be spent by June 08 is making it difficult for our county to plan and work effectively.
- Santa Barbara County is asking for clarification of the Reserve Fund DMH is requiring by 2010. The language in the 7/26 information notice is not clear. What happened to the County Accounts DMH was to set up for reserve purposes? How much is DMH holding back in reserves?
- Formulized attempts to give agreed upon percentages to each of the age groups in the various MHSA programs is sometimes better in theory than in practice and they discourage readdressing areas and services that are more needy than others.

County Funding and MHSA "Supplantation"

- Counties are using MHSA funds to bridge the gaps left by poor funding to counties.
- The county is using MHSA funds to create "new" programs to move current employees into because of cuts passed down by the state.
- County officials are reducing General Fund Support and Core Services to county mental health. MHSOAC commissioners must find a way to educate top level county officials about the consequences. I.E.; FSP's are completely dependent upon viable county core services to receive clients from FSP's when they are stabilized and on the road to recovery. Without viable core services, FSP programs and MHSA programs turn into another revolving door.
- Riverside County Board of Supervisors voted 5-0 to end participation in Medi-cal mental health programs if the state does not increase funding to the county.
- In our county, we see constant efforts to cut down on emergency services, emergency beds, and longer stays.

MHSA Transitions

- Dropping FSP clients from their FSP teams when they are moved into IMD's or other programs; moved from IMD's to step-down facilities; or discharged from hospitals to shelters or to the street leaves clients isolated and without familiar and trusted support at times of critical change.
- Grading systems based on "recovery" sets up some individuals (who are still going up and down) and programs to consider themselves failures.

Miscellaneous

- More proactive Crisis Intervention Team (CIT) effort is needed at the state level by California law enforcement agencies.
- Continued MHSA funding for outreach services is needed for all age groups such as Centralized Assessment Teams (CAT) in Orange County and Mobile crisis teams which pair police officers and mental health professionals sometimes called Psychiatric Emergency Response Teams (PERT) as requested by the counties of California.
- The Recovery Movement, sometimes called Recovery and Wellness, the empowerment of the patient, the alternative to the Medical Model, needs to be integrated with evidence-based practices in MHSA programs. Frederick J. Frese III, PhD in the article, "Integrating Evidence-Based Practices and the Recovery Model," suggests a hybrid theory that maximizes the virtues and minimizes the weaknesses of each model. (Psychiatric Services 52:1462–1468, 2001)